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# THE AMERICANS WITH DISABILITIES ACT AND THE CORPUS OF ANTI- DISCRIMINATION LAW: A FORCE FOR CHANGE IN THE FUTURE OF PUBLIC HEALTH REGULATION

Lawrence O. Gostin<sup>†</sup>

**L**EGAL CONTROLS over the unfettered exercise of public health powers have long been regarded as ineffective and idiosyncratic.<sup>1</sup> Public health statutes (many written before the sciences of virology, bacteriology and epidemiology had fully come of age) delegate wide ranging powers to officials.<sup>2</sup> The major check on the exercise of these powers has been constitutional review by the judiciary. The courts, however, are reluctant to interfere in public health decision making, and have not yet developed a cogent set of criteria for establishing effective boundaries around the proper exercise of public health authority.

This paper argues that constitutional review—long the standard bearer for judicial activity in the public health realm—is quietly, but effectively, being replaced with a more cogent statutory review. That review is provided by disability law. The advent of disability

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1. See Scott Burris, *Rationality Review and the Politics of Public Health*, 34 VILL. L. REV. 933, 933-82 (1989). Scott Burris, *Fear Itself: AIDS, Herpes, and Public Health Decisions*, 3 YALE L. & POL'Y REV. 479 (1985); Deborah Jones Merritt, *Communicable Disease and Constitutional Law: Controlling AIDS*, 61 N.Y.U. L. REV. 739 (1986); Wendy Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53 (1985); Wendy Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era*, 20 HASTINGS CONST. L. Q., Spring 1993 (forthcoming).

2. Lawrence Gostin, *The Future of Public Health Law*, 12 AM. J. L. & MED. 461 (1986).

law is remarkably recent. The first comprehensive federal disability statute was not enacted until the Rehabilitation Act of 1973. The Rehabilitation Act was followed by perfecting amendments (e.g., the Civil Rights Restoration Act of 1988) and new statutes (e.g., the Fair Housing Amendments of 1988), culminating in the landmark Americans with Disabilities Act of 1990 (ADA).

The ADA and the corpus of disability law are regarded as highly effective mechanisms to redress discrimination and remove physical barriers for people with disabilities. Remarkably, the legislative history of the Rehabilitation Act shows that Congress gave only the scantiest attention to the possibility that the law might apply to communicable disease. Indeed, the definitive affirmation of the role of disability law to protect persons with infectious conditions did not occur until the Supreme Court's *Arline* decision in 1987.<sup>3</sup>

Even in the Congressional deliberations on the ADA, confusion reigned as to whether and how the ADA might control the exercise of public health powers, and whether the ADA should preempt state communicable disease laws. The Congress viewed this question in a most narrow and uninformative way during the debates on the distracting question of food handlers.

The judicial and congressional inattention to the broader public health impact of the ADA is ill-conceived. I will argue that this landmark legislation will unleash a powerful review mechanism that will set effective boundaries on the historic exercise of public health powers. This statutory review will, moreover, gradually supplant much, but not all, of the constitutional analyses in the public health sphere. Ultimately, the ADA will provide a much needed impetus for states to reform fundamentally outdated statutes relevant to communicable and sexually transmitted disease. This reformation will bring state statutes into conformity with the letter and spirit of the ADA.<sup>4</sup>

First, this paper will review the constitutional history of the courts' attempts to check the powers of the public health department. Such a review will demonstrate how ineffective and inconsistent constitutional review has been, and suggest that adequate review criteria have not emerged. This section will show that, whether the courts are applying First, Fourth, or Fourteenth

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3. *School Bd. of Nassaw County, Fla. v. Arline*, 480 U.S. 273 (1987) (Rehnquist, J., dissenting).

4. The Milbank Memorial Fund and the U.S. Centers for Disease Control have sponsored a project on the future of communicable disease law chaired by the author.

Amendment standards, ultimately they are highly deferential to public health officials. Second, this paper will carefully examine the key concepts in the ADA as they apply to communicable disease. This section will reveal Congress' clear intention to include communicable disease, even asymptomatic infection, as a disability. It will also define and analyze the new "direct threat" standard in the ADA, particularly its application to exercise of public health powers under Title II (public services) of the Act. Finally, the paper will propose a standard of review under the ADA for the future regulation of public health powers.

### I. CONSTITUTIONAL PARAMETERS OF PUBLIC HEALTH POWERS: A DECIDEDLY DEFERENTIAL APPROACH

Constitutional review of the exercise of public health powers is plagued by a continuing sense of doctrinal uncertainty. The early courts were highly deferential to state public health regulation under the police powers. To some courts, the Constitution had "no application to this class of case."<sup>5</sup> "Where the police power is set in motion in its proper sphere, the courts have no jurisdiction to stay the arm of the legislative branch."<sup>6</sup> One court went so far as to declare the universality of the judicial rule that "constitutional guaranties must yield . . . to promote the public health."<sup>7</sup> Even as late as 1966, a court held that "drastic measures for the elimination of disease are not affected by constitutional provisions, either of the state or national government."<sup>8</sup>

Most courts have not totally abdicated their responsibility to set limits on the authority of public health departments. Certainly a set of minimalist principles can be ascertained. In the seminal case of *Jacobson v. Massachusetts*, the Supreme Court held that a vaccination requirement must have a "real or substantial relation" to public health objectives and could not be a "plain, palpable invasion of rights." The state "must refrain from acting in an arbitrary, unreasonable manner," or "going so far beyond what [is] reasonably re-

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5. *In re Caselli*, 204 P. 364, 364 (1922).

6. *Arizona ex rel. Conway v. Southern Pacific Co.*, 145 P.2d 530, 532 (1943) (quoting *State ex rel. McBride v. Superior Court*, 174 P. 973, 976 (1918)).

7. *People ex rel. Baker v. Strausz*, 54 N.E.2d 441, 444 (Ill. 1944).

8. *In re Halko*, 246 Cal. App. 2d 553, 566, 54 Cal. Rptr. 661, 663 (1966) citing *Larsen v. Board of Supervisors*, 214 N.W. 682, 684 (Iowa 1927), in *Deborah June Merritt, Communicable Disease and Constitutional Law: Controlling AIDS*, 61 N.Y.U. L. REV. 739 (1986).

quired for the safety of the public.”<sup>9</sup>

The “arbitrary, oppressive and unreasonable” standard is highly deferential. States need only show a good faith intention to promote the public health, as well as some medical evidence that the restriction of individual rights may be beneficial to the health of the community. Since *Jacobson*, no uniform and coherent set of criteria have emerged from the courts in reviewing public health powers.<sup>10</sup>

We like to believe that modern constitutional doctrine goes much further in setting rational boundaries around the exercise of public health powers. However, modern constitutional review is remarkably similar in approach to *Jacobson*. Although courts have occasionally engaged in more focused scrutiny, modern constitutional law in the public health sphere is drawn to be highly mechanistic. It places overly burdensome restrictions on some public health measures while placing virtually no restriction on others. It is difficult to predict the outcome of cases and so provides little guidance to legislators and public health officials. The courts have failed to establish clear criteria on the critical balance between restrictions on individual rights, level of risk to the public, and efficacy of the control measure. Courts have based their review of public health powers on either the Fourteenth Amendment, the Fourth Amendment, or the First Amendment, but a deferential balancing test, reminiscent of *Jacobson*, is evident irrespective of the constitutional vehicle.

#### A. Substantive Due Process and Equal Protection Under the Fourteenth Amendment

Constitutional theorists point to a highly mechanistic two-tiered<sup>11</sup> approach to judicial decision making which emerged during the last several decades.<sup>12</sup> The lowest level of scrutiny (the “ra-

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9. *Jacobson v. Massachusetts*, 197 U.S. 11, 28-31 (1905).

10. At various times, however, courts have required three conditions for upholding public health regulation. See *City of Cleburne, Tex. v. Cleburne Living Ctr., Inc.*, 473 U.S. 432 (1985) (requiring the true purpose of the power must be for the preservation of health and not some ulterior motive); *In re Martin*, 83 Cal. App. 2d 164, 188 P.2d 287, 291 (1948) (requiring that the subject of compulsory power actually be infectious before the control measure could be imposed); *ex parte Shepard*, 51 Cal. App. 49, 195 P. 1077 (1921) (requiring more than mere suspicion before invoking health regulation). See also *Jew Ho v. Williamson*, 103 F. 10, 22 (C.C.N.D. Cal. 1900) (great discretion is given to a state to decide which measures are necessary to protect the public health but the measure in itself should not pose a health risk to the subject).

11. A third tier, intermediate scrutiny, most often applied in instances of gender discrimination, is inapplicable in this analysis. See *Craig v. Boren*, 429 U.S. 190 (1976).

12. LAWRENCE TRIBE, *AMERICAN CONSTITUTIONAL LAW*, § 16 (2d. ed. 1988).

tional basis" test) validates state conduct which does not impinge upon a fundamental right or suspect class so long as it is reasonably related to a valid government purpose.<sup>13</sup> Since public health represents a highly beneficial purpose, courts afford the state "maximum deference"<sup>14</sup> under this standard of review. Courts often uphold the public health decisions of the state without a careful examination of benefits and risks in contexts ranging from classifying and reporting infectious disease,<sup>15</sup> to the control of sexually transmitted and needle-borne infections in bathhouses,<sup>16</sup> theaters,<sup>17</sup> bookstores,<sup>18</sup> and prisons.<sup>19</sup> In all of these cases the courts readily yield to the discretion of state officials. Issues critical to public health analysis barely surface under the lowest level of judicial review: whether the action is overly burdensome of individual rights, whether it comports with the clear weight of scientific opinion, and whether there are less restrictive ways of accomplishing the public health objective.

The highest level of judicial scrutiny occurs when states impinge on "fundamental" rights such as travel,<sup>20</sup> marriage,<sup>21</sup> and certain privacy interests associated with reproduction.<sup>22</sup> Strict scrutiny is also triggered if the state burdens certain "suspect" classes such as race<sup>23</sup> or national alienage.<sup>24</sup> Such measures must be narrowly tailored to serve a compelling objective, and must be the least restrictive alternative for achieving that objective.<sup>25</sup>

These two traditional tiers of constitutional review are outcome

13. See, e.g., *Kardmas v. Dickinson Public Schools*, 108 S.Ct. 2481, 2489-90 (1988).

14. James A. Kushnar, *Substantive Equal Protection: The Rehnquist Court and the Fourth Tier of Judicial Review*, 53 Mo. L. Rev. 423, 449-50 (1988).

15. See *New York State Society of Surgeons v. Axelrod*, 157 A.D.2d 54 (N.Y. App. Div. 1990) (holding that nothing positive would be gained by designation of HIV infection as a communicable or sexually transmissible disease).

16. *City of N.Y. v. New St. Mark's Baths*, 130 Misc. 2d 911 (N.Y. Sup. 1986), *aff'd*, 122 A.D. 2d 747 (1986); *People v. 3Mc S. AIDS Lit. RPTR.*, Sept. 9, 1988; *Los Angeles v. Benson*, AIDS LIT. RPTR., May 13, 1988.

17. *Public Health: Theatre Closure*, AIDS LIT. RPTR., Oct. 28, 1988, at 1640.

18. E.g., *Movie & Video World, Inc. v. Board. of Comm'rs of Palm Beach*, 723 F. Supp. 695 (S.D. Fla. 1989).

19. E.g., *Muhammad v. Carlson*, 845 F.2d 175 (8th Cir. 1988), *cert. denied*, *Muhammad v. Quinlan*, 489 U.S. 1068 (1989); see also, *Doe v. Coughlin*, 518 N.E. 2d 536, 523 N.Y.S.2d 782 (1987), *cert denied*, 488 U.S. 879 (1988).

20. *Shapiro v. Thompson*, 394 U.S. 618, 629-31 (1969).

21. *Loving v. Virginia*, 388 U.S. 1, 12 (1966); *Zablocki v. Redhail*, 434 U.S. 374, 383-84 (1978).

22. See *Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965).

23. See, e.g., *Regents of the University of California v. Bakke*, 438 U.S. 265 (1978).

24. See, e.g., *Graham v. Richardson*, 403 U.S. 365 (1971).

25. E.g., *Kramer v. Union Free School District*, 395 U.S. 621, 627 (1969); Cf., *Adding-*

determinative. Once the standard of review is decided upon, it is highly predictive of the decision of the court. Thus, public health measures which burden personal freedom (e.g., isolation or quarantine), marriage (e.g., a ban on marriage of persons with sexually transmitted infections), or define a class based upon race (e.g., strict limitations on sickle cell disease) theoretically ought to be subject to intensive review.<sup>26</sup> The public health justification would have to overwhelm the human rights concerns. If, however, the public health measure did not directly burden these almost arbitrary touchstones of constitutional jurisprudence, they might receive a perfunctory examination, where the courts almost obsequiously yield to public health judgements. In either case, there is little room for clear and cogent review criteria which carefully measure risk, efficacy, alternatives, and human rights burdens.

While the Supreme Court is slowly moving from this rigid tiered approach to constitutional review, the Court's new decision-making process is still largely uninformative and unpredictable. The *Cleburne*<sup>27</sup> doctrine, often referred to as a third tier of constitutional review, does not take the inquiry much further than the post-*Jacobson* "true purpose" test.<sup>28</sup> The *Cleburne* court invalidated a zoning ordinance excluding group homes for mentally handicapped people. The Court did not raise its standard of review, but nevertheless searched into the record to conclude that no rational basis existed to warrant a legislative finding that mentally handicapped people posed a threat. What the legislature may not do is base its decision on "vague, undifferentiated fears" or "irrational prejudice."<sup>29</sup>

Recently, the court has refrained from finding new "fundamen-

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ton v. Texas, 441 U.S. 418, 427 (1979) (state must justify confinement by proof more substantial than a mere preponderance of the evidence).

26. As late as the 1960's, however, courts were treating public health decisions offering liberty as if they did not require serious scrutiny at all. See *In re Halko*, 246 Cal. App. 2d 553, 54 Cal. Rptr. 661 (2d Dist. 1966) (upholding isolation of persons with pulmonary tuberculosis without any inquiry as to whether it was essential to the public health; only question asked by the court was whether the health officer had probable cause to believe the person had an infectious disease). "The Legislature is vested with broad discretion in determining what are contagious and infectious diseases and in adopting means for preventing the spread thereof." 246 Cal. App. 2d at 557; See also, *Moore v. Armstrong*, 149 So. 2d 36 (S.Ct. Fla. 1963) (upholding detention of person in a tuberculosis hospital).

27. *City of Cleburne, Tex. v. Cleburne Living Center, Inc.*, 473 U.S. 432 (1985).

28. See *Loving v. Virginia*, 388 U.S. 1, 12 (1966); *Zablocki v. Redhail*, 434 U.S. 374, 383-84 (1978).

29. *City of Cleburne*, 473 U.S. at 449, 450. See also, *Brennan v. Stewart*, 834 F.2d 1248, 1258 (5th Cir. 1988) (decisions based on physical and mental disabilities should be reviewed "somewhat closer than usual").

tal" rights, particularly in medically related fields. Rather, courts have referred to a series of "liberty interests" to refuse psychotropic medication,<sup>30</sup> avoid admission to mental hospitals,<sup>31</sup> or to withdraw life sustaining treatment.<sup>32</sup> The right to be left alone by public health officials or doctors, is, however, only one interest to be balanced against a series of competing state interests. Notably, in each of these cases, the state interests prevailed over the liberty interest of the individual. In essence, the Court's notion of a "liberty interest" is so weak that it begins to resemble a rational basis test—the medical activity is upheld so long as the state can point to some legitimate justification. The Court certainly has not yet enunciated how collective and personal interests will be balanced or reconciled in particular cases.

#### B. Search and Seizure: Blood and Urine Tests, Screening, and the Fourth Amendment

The Fourth Amendment's prohibition on unreasonable searches and seizures has long been construed to apply to blood and urine tests. Under the Warren Court's *Schmerber* doctrine, probable cause, or at least individual suspicion, must exist before testing without consent: "warrants are ordinarily required for searches of dwellings and absent an emergency, no less could be required where intrusions into the human body are concerned."<sup>33</sup> The courts recognize that "the integrity of an individual's person is a cherished value . . . which is protected from unreasonable searches and seizures."<sup>34</sup>

The *Schmerber* doctrine ought not to be susceptible to the same vacuous balancing test that occurs under the Fourteenth Amendment, but that is exactly where it is leading.

The Supreme Court assigns a privacy value to be free from forced medical testing. But it balances that privacy value against the intrusiveness of the bodily search and the public interest it is designed to effectuate. The Court has recognized state interests such as "national security"<sup>35</sup> and "public safety"<sup>36</sup> in drug testing

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30. *Washington v. Harper*, 494 U.S. 210, 221 (1990).

31. *Parham v. J.R.*, 442 U.S. 584 (1979).

32. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

33. *Schmerber v. California*, 384 U.S. 757, 770 (1966).

34. *People v. Bracamonte*, 540 P.2d 624, 632 (S.Ct. Cal. 1975) quoting *Schmerber v. California*, 384 U.S. 757, 772 (1966).

35. *National Treasury Employees Union v. Von Raab*, 489 U.S. 656, 674 (1989).

36. *Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602, 615 (1989) ("permissibil-



without any careful examination of whether testing will achieve the stated objective.

The Court is quietly abandoning each of the key principles of the *Schmerber* doctrine including the requirement of a warrant, individualized suspicion or probable cause, and a clear nexus to achievable public health goals. For example, courts have used the "special needs" doctrine to justify nonconsensual testing of sexual offenders conducted without the procedural safeguards of a warrant or individualized suspicion.<sup>37</sup> Courts have also declared that the judiciary may use equitable authority to compel testing in the absence of statutory authority.<sup>38</sup> The result of this disintegration of the *Schmerber* doctrine is a pure balancing test where little guidance is provided on which interests weigh more heavily, and where public health discretion is generally upheld.

Courts have been highly deferential in reviewing federal and state screening programs. Federal courts have upheld HIV screening in the Departments of State<sup>39</sup> and Defense,<sup>40</sup> and cases are pending challenging screening of Job Corps applicants<sup>41</sup> as well as immigrants and temporary visitors to the United States.<sup>42</sup> Since HIV is not transmitted casually, and there is little risk of transmission by any known modality in these settings, it is difficult to conceive how large scale indiscriminate screening achieves rigorous public health objectives.<sup>43</sup>

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ity of a particular practice is judged by balancing its intrusion on the individual's Fourth Amendment interests against its promotion of legitimate governmental interests").

37. In the Matter of Juveniles A, B, C, D, and E, 847 P.2d 455 (Wash. 1993) (holding that a statute requiring mandatory HIV testing of convicted sex offenders applied to juveniles under the "special needs" doctrine where the state's interest in testing high risk groups and protecting society from the spread of HIV outweighed the privacy interests of the offenders, the statute was narrowly-tailored to the purpose, and the testing was not conducted for law enforcement purposes).

38. *Syring v. Tucker*, 498 N.W.2d 370 (Wis. 1993) (holding that the circuit court, despite the absence of statutory authority, had authority in equity to compel HIV testing of a woman who bit a social worker).

39. *Local 1812, Am. Fed'n of Gov't Employees v. U.S. Dept. of State*, 662 F. Supp. 50 (D.D.C. 1987).

40. *Batten v. Lehman*, U.S.D.C. Cal., No.85-4108, Jan. 18, 1986.

41. *Dorsey v. U.S. Dept. of Labor*, U.S.D.C. No. 88-1898.

42. See Larry Gostin et al., *Screening Immigrants and International Travelers for the Human Immunodeficiency Virus*, 322 NEW ENG. J. MED. 1743, 1743-46 (1990). With regard to recent HIV testing of Haitian immigrants seeking refuge in the United States, the United States District Court found that subjecting HIV positive detainees to a second screening, conducted without an attorney present, violated the Refugee Act and the Due Process rights of the detainees. *Haitian Centers Council, Inc. v. Sale*, 823 F.Supp. 1028 (E.D.N.Y. 1993).

43. See Gostin, *supra* note 42, at 1743-46; see also, Larry Gostin et al., *The Case Against*

In *Leckelt*<sup>44</sup> the court rejected a Fourth Amendment claim by a nurse who was required to be tested for HIV against his will. The hospital argued that the test was necessary to protect the health of patients, even though there was not a single case of health care professional-to-patient transmission of HIV at the time.<sup>45</sup> Kevin Leckelt's medical condition (infection with the Hepatitis B Virus), apparent homosexuality, and long term relationship with a partner with AIDS meant that the hospital had individualized suspicion. The court, without any finding that Leckelt posed a significant risk to patients or staff, upheld the testing because of the generalized need to protect the health of employees and prevent the spread of infectious disease.

Curiously, another federal Court of Appeals found that indiscriminate HIV screening of all hospital staff violated the Fourth Amendment because the "risk was low, approaching zero."<sup>46</sup> Certainly, these cases can be distinguished because one involved individualized suspicion and the other a broader screening program. Still, the public health justifications were similar, and no data could be offered showing even an elevated risk to patients.

### C. Freedoms of Expression and Religion: Does the First Amendment Effectively Impede Public Health Officials in the Exercise of their Authority?

At the heart of the conflict between public health and individual

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*Compulsory Casefinding in Controlling AIDS: Testing, Screening, and Reporting*, 12 AM. J.L. & MED. 7, 19-20 (1986).

44. *Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1*, 909 F.2d 820, 832-33 (5th Cir. 1990).

45. There is one instance of believed transmission of HIV infection from a health care professional to patients, that of the dentist, Dr. David Acer, in Florida. Dr. Acer may have transmitted the virus to as many as five patients, including Kimberly Bergalis, who later testified before Congress regarding health care professional-to-patient transmission. The Centers for Disease Control has promulgated guidelines to prevent this type of transmission, calling for the use of universal precautions in the care of all patients, especially in procedures involving blood and other bodily fluids such as semen, vaginal secretions and amniotic fluid. Some specifications of universal precautions include 1) use of barrier protection such as gloves and goggles, 2) immediate washing of hands after performing procedures, 3) careful use of sharp instruments to prevent injury, and 4) prohibition of health care professionals with exudative lesions or weeping dermatitis from direct patient care. Centers for Disease Control, *Update: Universal Precautions for Prevention of Transmission of the Human Immunodeficiency Virus, Hepatitis B Virus and Other Bloodborn Pathogens in Health-Care Settings*, 37 MORBIDITY & MORTALITY WEEKLY REP. 277 (1988); see also Larry Gostin, *Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 Md. L.Rev. 12, 24 (1989).

46. *Glover v. Eastern Neb. Community Office of Retardation*, 867 F.2d 461, 463 (8th Cir. 1989), cert. denied, 493 U.S. 932 (1989).

rights is the claim by citizens that they possess fundamental freedoms which public health officials cannot diminish. Many public health cases have been adjudicated under the First Amendment because the subjects of regulation claim that it interferes with their freedom of expression, association, or religion. Two paradigmatic cases emerge: first, the right of persons to refuse compulsory vaccination<sup>47</sup> or treatment<sup>48</sup> because it is contrary to their religious beliefs<sup>49</sup> and, second, the rights of persons to frequent bathhouses, video stores, theaters, and other public places in the exercise of their freedoms of expression and association. Despite the absolutist language of the First Amendment (Congress shall pass "no law" abridging these freedoms), the courts have resorted to a familiar balancing test where state interests are afforded great weight and deference.

### 1. Compulsory vaccination cases

A great majority of states have enacted compulsory or local option vaccination statutes. These statutes were the subject of frequent constitutional attack and were almost universally upheld.<sup>50</sup> While freedom of religion was not a central concern in all cases,<sup>51</sup> many courts upheld compulsory vaccination in the face of First Amendment claims.<sup>52</sup> Freedom of religion does "not import an ab-

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47. See, e.g., *Brown v. Stone*, 378 So. 2d 218 (Miss. 1979) (holding that interests of school children prevail over parents' religious beliefs) *cert. denied*, 449 U.S. 887 (1980).

48. *State ex rel. Holcomb v. Armstrong*, 239 P.2d 545 (Wash. 1952) (upholding chest x-ray requirement as condition for university registration against religious challenge).

49. *Maricopa County Health Dept. v. Hammon*, 750 P.2d 1364 (Ariz. Ct. App. 1987) (holding that policy of the state is "to balance the individuals' rights to education against the states' need to protect against the spread of infectious and contagious disease).

50. *Itz v. Penick*, 493 S.W.2d 506 (Tex. 1973) (holding that except in certain religious and medical exemptions, mandatory immunization before admission into school does not interfere with parents' rights, equal protection, due process, delegation of power, or access to education). *But see*, *Davis v. Maryland*, 451 A.2d 107 (Md. 1982) (holding that the legislature's religious exemption from compulsory immunization must not violate the Establishment clause).

51. Several courts have upheld the statute on grounds other than the First Amendment. See, e.g., *Heard v. Payne*, 665 S.W.2d 865, 867 (Ark. 1984) (holding that a chiropractor who believes children are allergic to vaccine is not permitted to exempt them from immunization) *reh'g denied* (1984); *State ex rel. Mack v. Board of Educ.*, 204 N.E.2d 86, 89 (Ohio Ct. App. 1963) (holding that child does not have absolute right to enter school without immunization solely based on parent's objection) *reh'g denied* (1963); *Pierce v. Board of Educ. of Fulton*, 219 N.Y.S.2d 519, 520 (N.Y. 1961) (upholding statute despite parents' belief that vaccination would be detrimental to their children); *Stull v. Reber*, 64 A. 419, 419 (Pa. 1906) (holding that lack of consent to vaccination is not trespass on individual's rights).

52. Many courts have used the rationale that public health takes precedence over religious freedom. See, e.g., *Brown v. Stone*, 378 So.2d 218, 220 (Miss. 1979) *reh'g denied* (1980), and *cert. denied*, 449 U.S. 887 (1980); *Wright v. DeWitt Sch. Dist.*, 385 S.W.2d 644,

solute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good."<sup>53</sup> Indeed, compulsory vaccination need not even be triggered by the existence of an epidemic<sup>54</sup>; nor must a grave or immediate health risk exist to outweigh religious liberty.<sup>55</sup> However, one court has refused to intervene when the urgency previously created by an epidemic has passed.<sup>56</sup>

Courts, however, do not allow public health officials completely free reign to immunize the community from preventable disease. While the state may vest broad discretion in its officials,<sup>57</sup> they must regulate fairly.<sup>58</sup> Public health officials have broad discretion under many state statutes to provide a religious exemption to vaccination, but they cannot exercise this discretion arbitrarily.<sup>59</sup>

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646 (Ark. 1965); *Cude v. State*, 377 S.W.2d 816, 819 (Ark. 1964) *reh'g denied* (1964); *Sadlock v. Board of Educ. of Carlstadt*, 58 A.2d 218, 220 (N.J. 1948). Moreover, the Supreme Court has made plain its view that public health imperatives in vaccination programs overrides religious freedoms and that a state need not provide a religious exemption for its immunization program in dictum. See, *Prince v. Mass.*, 321 U.S. 158, 166-67 (1944), *cert. denied*, 321 U.S. 804. A New York court has required a demonstration that opposition to inoculation stem from sincerely held religious convictions and not merely be framed in terms of religious belief in order to gain the exemption required. In the *Matter of Christine M.*, 595 N.Y.S.2d 606 (1992).

53. *Syska v. Montgomery County Bd. of Educ.*, 415 A.2d 301, 304 (Md. Ct. Spec. App. 1980) *citing Jacobson v. Massachusetts*, 197 U.S. 11, 26 (1905) (holding that compulsory rubella immunization for school admission did not violate mother's constitutional right).

54. See *In re Elwell*, 284 N.Y.S.2d 924, 930 (N.Y. Fam. Ct. 1967) (holding that compulsory vaccination for school admission is valid exercise of the state police power to prevent against disease). See also, *Board of Educ. v. Maas*, 152 A.2d 394 (N.J. Super. Ct. App. Div. 1959) *cert. denied*, 363 U.S. 843 (1960) (holding that vaccinations are an effective health measure and are within the power of the legislature).

55. *Wright v. DeWitt Sch. Dist.*, 385 S.W.2d 644 (Ark. 1965) (holding that mandatory vaccination outweighs religious liberty even when there is no grave or immediate health risk).

56. *In the Matter of Christine M.*, 595 N.Y.S.2d 606 (1992).

57. See *Zucht v. King*, 260 U.S. 174 (1922) (holding that it is constitutional for public officials to be vested with the authority to enforce compulsory school vaccinations for the protection of public health).

58. *Raper v. Lucey*, 488 F.2d 748, 753 (1st Cir. 1973). See *Avard v. Dupuis*, 376 F. Supp. 479, 482 (D.N.H. 1974) (holding the religious exemption standardless and unconstitutional).

59. *Brown v. Stone*, 378 So.2d 218 (Miss. 1979) (holding that provisions of a compulsory vaccination statute providing religious exceptions violated the Equal Protection Clause); *Kolbeck v. Rutgers, the State Univ.*, 202 A.2d 889, 893 (N.J. Super. Ct. App. Div. 1964) (holding that the state cannot show a preference for one religion over another when creating exemptions for mandatory vaccinations); *Davis v. Maryland*, 451 A.2d 107, 113 (Md. 1982) (holding that a student vaccine exemption which recognizes that parents are members of a recognized church or religious denomination violates the Establishment Clause of the First Amendment).

## 2. The bathhouses and adult video shop cases

Government action to impede the spread of sexually transmitted infection has often focused on the closure or regulation of public places such as bathhouses, adult video shops, theaters, and bookstores.<sup>60</sup> Regulation of public places, particularly where literature, films, or live theater is presented, implicates the First Amendment freedoms of expression, press, and association. Theoretically, these freedoms cannot be abridged absent a "substantial governmental interest."<sup>61</sup> Nonetheless, courts have shown little hesitation in upholding regulation, even closure, of such establishments in the name of public health.<sup>62</sup> To these courts, the preservation of public health is an overriding state purpose.<sup>63</sup> Because of the presence of a compelling public health objective, courts have not always required that the state prove the restriction on First Amendment rights is strictly necessary. Governments have broad latitude in experimenting with possible solutions to public health problems.<sup>64</sup> Thus, courts faced with free expression or association claims require only some reasonable scientific evidence of a public health necessity, even if there is an equally respected scientific view that the restriction is not essential to the public health.<sup>65</sup>

The bathhouse cases emerge as powerful examples of scientific

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60. *E.g.*, *City of New York v. New Saint Mark's Bath*, 497 N.Y.S. 2d 979, 983 (N.Y. App. Div. 1986) (holding that closure of bathhouse would not violate First Amendment rights of association and privacy); *Mitchell & Bob's Discount Adult Bookstore, Inc. v. Commissioner of the Comm'n on Adult Entertainment Establishments of the State of Delaware*, 802 F.Supp. 112 (D.Del. 1992) (holding that ordinance amendments regulating hours of adult book stores and prohibiting closed booths are Constitutional as means to further state interest of curbing the spread of AIDS).

61. *United States v. O'Brien*, 391 U.S. 367, 377 (1968) (laying down a four part test: 1) the regulation must be within the constitutional power of the government; 2) it must further an important or substantial government interest; 3) the government interest must be unrelated to the suppression of free expression; and 4) the incidental restriction on First Amendment freedoms must be no greater than is essential to the furtherance of that interest).

62. *See generally*, Stephen L. Collier, Comment, *Preventing the Spread of AIDS by Restricting Sexual Conduct in Gay Bathhouses: A Constitutional Analysis*, 15 *GOLDEN GATE U.L. REV.* 301 (1985); Note, *The Constitutional Rights of AIDS Carriers*, 99 *HARV. L. REV.* 1274 (1986).

63. *E.g.*, *State v. Mountain Timber Co.*, 135 P. 645, 647 (Wash. 1913), *aff'd*, 243 U.S. 219 (1916) (holding that the police power of the state permits interference with individual liberty whenever public interest demands it).

64. *E.g.*, *Whalen v. Roe*, 429 U.S. 589 (1977) (holding that state legislation which affects individual liberty or privacy may not be held unconstitutional simply because the court found it unnecessary); *See also*, *Paris Adult Theater I v. Slaton*, 413 U.S. 499 (1973) (holding that the state can regulate obscene material although there is a lack of definite proof of a nexus between anti-social behavior and obscene material).

65. *See generally*, Burris, *Rationality Review and the Politics of Public Health*, 34 *VILL. L. REV.* 933, 969 (1989).

uncertainty about the best public health approach.<sup>66</sup> To some, the health risk represented by sexual activity with anonymous partners in bathhouses is unmistakable. To others, however, closure only means that sexual activity will move to another venue, and an opportunity for targeted health promotion would be lost. In upholding the closure of bathhouses,<sup>67</sup> courts reasoned that they need not choose among reasonable scientific alternatives: "The judicial function is exhausted with the discovery that the relation between means and end is not wholly vain and fanciful, and illusory pretense."<sup>68</sup> Even when operating under the First Amendment, therefore, the courts will not gage the scientific merits of decisions to close public places.<sup>69</sup>

Still less clear is the impact of adult video stores, theaters, or bookstores in contributing to the spread of sexually transmitted infections. Federal<sup>70</sup> and state<sup>71</sup> courts have almost universally up-

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66. See generally, RONALD BAYER, *PRIVATE ACTS, SOCIAL CONSEQUENCES: AIDS AND THE POLITICS OF PUBLIC HEALTH* (1989).

67. *California v. Three 3MCS, Inc.* No. C685816 slip op (Cal. Sup. Ct. Aug. 30, 1988); *Los Angeles v. Benson*, Super. Ct. LA City, Cal. AIDS Lit. Rptr.; May 13, 1988. See also, *City of New York v. Big Apple Spa*, 130 Misc. 2d 920, 497 N.Y.S.2d 988 (N.Y. Sup. Ct. 1986) (court used same rationale with regard to heterosexual conduct).

68. *City of New York v. New Saint Mark's Bath*, 497 N.Y.S.2d 979, 983 (N.Y. App. Div. 1986) (holding that closure of bathhouse would not violate First Amendment rights of association and privacy).

69. *California v. Three 3MCS, Inc.*, No. C685816, slip op at 8-9 (Cal. Sup. Ct. Aug. 30, 1988) ("it is not the function of the courts to determine which scientific view is correct"). One notable exception occurred in San Francisco where a less restrictive alternative was required so that bathhouses could remain open subject to strict regulation designed to decrease unprotected sexual activities. *California ex rel. Agnost v. Owen*, No. 830 321 (Cal. Sup. Ct. Nov. 30, 1984).

70. *E.g., Mitchell & Bob's Discount Adult Bookstore, Inc. v. Commissioner of the Comm'n on Adult Entertainment Establishments of the State of Delaware*, 802 F.Supp. 112 (D.Del. 1992) (holding that ordinance amendments regulating hours of adult book stores and prohibiting closed booths are Constitutional as means to further state interest of curbing the spread of AIDS); *Bamon Corp. v. City of Dayton*, 923 F.2d 470 (6th Cir. 1991) (affirming summary judgment in favor of city ordinance regulating open doors in adult book stores); *Postscript Enterprises v. City of Bridgeton*, 905 F.2d 223 (8th Cir. 1990) (affirming summary judgment in favor of ordinance requiring open doors for viewing areas in adult book store); *Wall Distrib., Inc. v. City of Newport News*, 782 F.2d 1165, 1168 (4th Cir. 1986) (holding that ordinances making it a criminal offense to exhibit films in enclosed booths was valid restriction on manner of speech); See also, *Ellwest Stereo Theaters, Inc. v. Wenner*, 681 F.2d 1243, 1246 (9th Cir. 1982) (holding that city ordinance requiring that viewing areas of booth in which coin-operated viewing devices are located be visible from main aisle is reasonable regulation of manner in which films may be viewed); *Movie & Video World v. Board of County Comm'rs*, 723 F. Supp. 695, 701 (S.D. Fla. 1989) (upholding regulation that all doors be removed from booths showing sexually explicit films); *Doe v. City of Minneapolis*, 898 F.2d 612 (8th Cir. 1990) (upholding constitutionality of ordinance requiring removal of doors to booths in adult book stores); *Suburban Video v. City of Delafield*, 694 F. Supp. 585, 587 (E.D. Wis. 1988) (holding that open door requirement of booths did not violate 1st Amend-

held the constitutionality of local ordinances that require viewing booths to be open and viable to the public. Courts have validated the delegation of authority to local governing bodies such as county health departments and Boards of Supervisors, declaring such ordinances akin to those passed by the legislature itself.<sup>72</sup> Again, courts do not require the risk to public health to be proven.<sup>73</sup> The government is entitled to "infer" a health threat from evidence that more than one person sometimes occupies a booth at the same time.<sup>74</sup> Equal protection and undue burden arguments regarding open viewing booths have also been rejected by the courts.<sup>75</sup>

The goal of regulation is to prevent sexual activity, including masturbation, "and its related unsanitary conditions and other activities offensive to decency that demonstrably accompany furtive

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ment rights); *Berg v. Health & Hosp. Corp.*, 667 F. Supp. 639, 641 (S.D. Ind. 1987) (upholding constitutionality of open door requirement), *aff'd*, 865 F.2d 797 (7th Cir. 1989); *Broadway Books v. Roberts*, 642 F. Supp. 486, 492 (E.D. Tenn. 1986) (upholding validity of open booth requirement).

71. *City News & Novelty, Inc. v. City of Waukesha*, 487 N.W.2d 316 (Wis.Ct.App. 1992) (affirming summary judgment for city ordinance requiring viewing booths to be viewable from public points in adult oriented establishments as a means to control the spread of communicable diseases like AIDS); *City of Lincoln, Neb. v. ABC Books, Inc.*, 470 N.W.2d 760 (Neb. 1991) (denying injunctive relief from ordinance that required visibility of booths in an adult book store); *Centaur, Inc. v. Richland County, S.C.*, 392 S.E.2d 165 (S.C. 1990) (upholding constitutionality of ordinance requiring unobstructed view of every area in interior of sexually oriented businesses); *Adult Entertainment Ctr., Inc. v. Pierce County*, 788 P.2d 1102, 1106 (Wash. Ct. App. 1990) (holding that open booth requirement of ordinance providing for licensing of businesses providing booths for their customers to view sexually explicit material was reasonable time, place, and manner restriction); *See also, Rahmani v. State*, 748 S.W.2d 618, 621 (Tex. Ct. App. 1988) (holding that permit requirements did not constitute impermissible prior restraint on free speech), *cert. denied*, 490 U.S. 1081 (1989); *Lopex v. State*, 756 S.W.2d 49, 51 (Tex. Ct. App. 1988) (upholding validity of local ordinance requiring a permit as proof of interior design compliance to discourage the use of an adult arcade as a place for sexual encounters); *EWAP Inc. v. City of Los Angeles*, 97 Cal. App. 3d 179, 182 (1979) (upholding ordinance denying permits for the operation of picture shows if any person involved knowingly allowed any sexual acts or solicitations for such acts in the picture arcade).

72. *Marsoner v. Pima County*, 803 P.2d 897 (Ariz. 1991) (reversing appellate court decision that Board of Supervisors lacked authority to enact ordinance requiring licensing of adult amusement establishments).

73. *Adult Entertainment Ctr. v. Pierce County*, 788 P.2d at 1105 (when holding the open booth requirement as constitutional, the court noted that the necessity for the legislation need not be proven absolutely).

74. *Id.* at 1105-06 (requiring the testimony of only one person in booth as sufficient to claim health risk).

75. *Doe v. City of Minneapolis*, 898 F.2d at 620-22 (holding that ordinance requiring removal of doors to booths in adult book stores treated similarly situated commercial establishments the same; economic effect on book stores not controlling in First Amendment analysis).

viewings of sexually explicit materials."<sup>76</sup> Courts have viewed regulation of book stores and video shops for public health purposes as "time, place, and manner" restrictions.<sup>77</sup> Regulation of these shops were upheld because they were content-neutral and narrowly tailored to serve a public health purpose, and left ample alternative channels of communication.<sup>78</sup> Local officials, however, may not impose onerous licensing requirements such as demanding a high moral character from the proprietor or an inordinately expensive license fee.<sup>79</sup>

The lack of clear standards of constitutional review results in inconsistent and unpredictable decision making, and gives little guidance as to the lawfulness of an array of public health powers. The Americans with Disabilities Act and the corpus of anti-discrimination law should close that doctrinal gap in the public health sphere.

## II. THE AMERICANS WITH DISABILITIES ACT AND THE CORPUS OF ANTI-DISCRIMINATION LEGISLATION

The Americans with Disabilities Act of 1990<sup>80</sup> (ADA) and the corpus of anti-discrimination legislation<sup>81</sup> appear to be unlikely

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76. *Adult Entertainment Ctr. v. Pierce County*, 788 P.2d at 1106 (citing *Wall Distrib. Inc. v. City of Newport News*, 782 F.2d 1165 (4th Cir. 1986)).

77. *E.g.*, *City of Renton v. Playtime Theaters*, 475 U.S. 1132 (1986) *reh'g denied*, 475 U.S. 1132 (1986).

78. *See Ward v. Rock Against Racism*, 491 U.S. 781 (1989).

79. *Suburban Video v. City of Delafield*, 694 F. Supp. 585, 592 (E.D. Wis. 1988) (holding that licensing requirements that do not further substantial government interest contravene constitutional rights); *Broadway Books v. Roberts*, 642 F. Supp. 486, 494-95 (E.D. Tenn. 1986) (holding unconstitutional a 30 day residence requirement that does not demonstrate a compelling state interest and a good moral character requirement which permits unguided discretion to licensing authority); *but see Centaur, Inc. v. Richland County, S.C.*, 392 S.E.2d 165 (S.C. 1990) (upholding constitutionality of licensing requirement, but permitting denial of license under enumerated circumstances such as failure to provide "reasonably necessary information").

80. The Americans with Disabilities Act of 1990, 42 U.S.C. § 12101-12201 (1992) (established a clear and comprehensive prohibition of discrimination on the basis of disability).

81. The ADA does not repeal the body of anti-discrimination legislation that preceded it. The Federal Rehabilitation Act of 1973 proscribes discrimination of persons with "handicaps" (defined almost identically to "disability") by entities which are in receipt of federal financial assistance and does not reach into the purely private sector. The principle application of the Rehabilitation Act in the post-ADA era will be to protect disabled employees of the federal government, since they are not covered by the ADA (§ 101(5)(B)(i)).

Discrimination against persons with disabilities in housing is dealt with under the Federal Fair Housing Amendments of 1988. *See Baxter v. Belleville*, 1989 U.S.D.C. LEXIS 10298 (S.D. I 11.1989).

The Education for All Handicapped Children Act, 20 U.S.C. para. 1400 *et seq.*, gives all school aged handicapped children the right to a free public education in the least restrictive



sources of law to fill the doctrinal void left by deferential constitutional standards. Anti-discrimination law, on its face, is concerned with what I will refer to as "pure discrimination." Pure discrimination occurs when a public or private entity treats a person unfairly, not because she lacks adequate skill, qualifications, or experience, but because of her disability. The primary goal of the ADA, then, is to assure equality of opportunity, full participation, equal living and self-sufficiency to allow people with disabilities to compete on an equal basis.<sup>82</sup>

Public health regulation of communicable disease does not fit comfortably within the ADA's rubric of pure discrimination. Certainly, the annals of public health are replete with examples of pure discrimination against "discrete and insular" minorities such as prostitutes,<sup>83</sup> drug dependent people,<sup>84</sup> gays,<sup>85</sup> and racial minorities.<sup>86</sup> The exercise of public health powers such as testing, screening, reporting, vaccination, treatment, isolation and quarantine are, however, qualitatively different than the ADA's paradigm of pure discrimination: the state is regulating public health, not withdrawing jobs, benefits or services because of a disability; here, the motive is health related, not grounded in prejudice; and the usual qualification standards of education, skill, or experience are not pertinent. Persons are treated unequally in public health regulation because of communicable medical conditions, not as a direct result of pure prejudice.

When a health department exercises public health powers, the pivotal issue is whether it must comply with the standards of the ADA. Despite the qualitative differences between a communicable disease (e.g., tuberculosis, syphilis, or hepatitis B), and a physical disability (e.g., sight, hearing, or mobility impairments), the ADA applies to each equally. Certainly, the actions of health departments that directly affect the opportunities of persons with communicable diseases in employment and in public accommodations are

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environment appropriate to their needs. See *Martinez v. Sch. Bd. of Hillsborough Cty, Fla.* 861 F.2d 1502 (11th Cir. 1988), reversing, 711 F. Supp. 1293 (M D Fla. 1989); *Community High School Dist. v. Denz*, 124 Ill. App. 3d 1291, 463 N.E. 2d 998 (2d Dist. Ill, 1984) (legislation and the judicial decisions construing them are referred to as the corpus of anti-discrimination law).

82. PL 101-336, § 2(a)(8), (9).

83. See ALLAN M. BRANDT, *NO MAGIC BULLET: A SOCIAL HISTORY OF VENEREAL DISEASE IN THE UNITED STATES SINCE 1880* (1985).

84. See generally, DONALD F. MUSTO, M.D., *THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL* (1973).

85. BAYER, *supra* note 59.

86. See *Jew Ho v. Williamson*, 103 F. 10 (C.C.N.D. Cal. 1900).

covered under Titles I and III respectively. If a health department required testing for disease or exclusion from a job in schools, hospitals, food service establishment or day care, it would undoubtedly have to comply with the standards in Title I of the ADA; the private entity in testing or excluding workers would be simply enforcing a state requirement. Similarly, if the health department required testing or exclusion of workers or residents in a public accommodation, it would have to comply with the standards in Title III of the ADA. Since public accommodation is defined to include health care providers, hospitals, day care centers, social services establishments, schools, and other entities traditionally regulated by health departments,<sup>87</sup> it is clear that ADA standards would apply.

It could be argued, however, that the ADA does not apply to health department regulations that do not directly affect opportunities in employment and public accommodations. The exercise of traditional public health powers such as screening, vaccination, reporting, contact tracing, and isolation are not specifically mentioned in the ADA. Title II (public services) does not refer to the exercise of police powers; exercising the authority of the state to protect public health, it can be argued, is not a "public service."

There are several reasons for the assertion in this essay that Title II does govern the exercise of traditional public health powers. Generally speaking, the exercise of traditional public health powers is a service provided to the public by health departments. The service is designed to protect the public and that protection is achieved both by voluntary and involuntary participation in public health programs. Any time a health department exercises compulsory powers it also expends resources, provides services, and protects the community. For example, the state buys and distributes vaccines and provides treatment and care for persons in isolation.

Moreover, it would be a bizarre reading of the ADA to make rigid distinctions among the various activities of government. When the state provides a service or benefit to a person, such as Medicare or food stamps, it undoubtedly has to do so in a non-discriminatory manner. The most striking example of this requirement was the recent denial of a Medicaid waiver to the State of Oregon when its proposed health plan discriminated against persons with disabilities. The original plan consistently rated the quality of life of persons with disabilities lower than that of non-disabled persons. Consequently, services provided to persons with disabili-

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87. See 42 U.S.C. § 12181(7) (1992).

ties were systematically placed in low (unlikely to be covered) positions on the priority list. The plan was found to violate the ADA.<sup>88</sup> Following revision to reflect ADA concerns, Oregon received its waiver.

Likewise, when a state exercises coercive powers with the potential to seriously affect a person's liberty, autonomy, or privacy, it should have the same obligation to follow the non-discrimination principles in the ADA. The exercise of public health powers is a substantial part of the functions of health departments. If Congress had intended to carve out, or exclude, these functions from the coverage of the ADA, it would have done so expressly and clearly.

Principles of parallel construction in the legislation also militate towards inclusion of public health powers. If a government department deprives an infected health care worker of a job, excludes a child from school, or refuses a medical license based upon a person's disease status, it clearly is covered. It seems inconceivable that if the same, or another government agency, coerces the individual or even deprives the person of liberty on the basis of a disease status, that the ADA does not apply. Such a tortuous construction would have to posit that Congress required health departments to act in a non-discriminatory manner when it withheld a small benefit or service, but not when it deprived a person of liberty.

Indeed, a great deal of evidence exists in Title II to suggest that its provisions apply to the exercise of traditional public health powers. The definition of "public entity" at 42 U.S.C. § 12131 expressly includes state and local governments. The definition squarely includes health department activities. Further, this section defines "qualified individual with a disability" to include eligibility to participate in programs or activities provided by a public entity. The "activities" of a health department assuredly include disease control.

Finally, 42 U.S.C. § 12132 contemplates coverage for persons who are subjected to the "activities" of a public entity, or "discrimination by any such entity." Discrimination by a health department would certainly include the exercise of compulsion against a person with a communicable disease without sufficient justification based upon a significant risk to the public. A public health department ought to be held to the same standard in exercising public health

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88. Letter from Louis W. Sullivan, Secretary, U.S. Department of Health and Human Services, to Barbara Roberts, Governor of Oregon (Aug. 7, 1992); Richard A. Knox, *U.S. Rejects Oregon Health Care Plan*, Boston Globe, Sept. 4, 1992, at 3. The Oregon plan, following revision to comply with the ADA, received its waiver.

powers as it is in employment or accommodations—grounding policies in facts and not in irrational fears about persons with disabilities.

The Department of Justice (DOJ) regulations relating to state and local government services also appear to cover the exercise of public health powers.<sup>89</sup> The DOJ sees its jurisdiction within the context of the “ADA’s expanded coverage of state and local government operations.”<sup>90</sup> It will exercise complaints against agencies and other governmental components carrying out their “functions,” including state medical boards. The DOJ’s jurisdiction extends expressly to “all programs, services, and regulatory activities” relating to “public safety” and “all other government functions not assigned to other designated agencies.”<sup>91</sup> Title II, therefore, covers “all actions of state and local governments”<sup>92</sup> which squarely include the exercise of their compulsory powers.

DOJ regulations under Title II liberally discuss individualized assessment and “direct threat standards” for tuberculosis and other communicable diseases.<sup>93</sup> To demonstrate the applicability of the ADA to communicable disease, the relevant definitions, legislative history, and standards are analyzed.<sup>94</sup>

### A. Communicable Disease as a Disability

#### 1. “Physical or mental impairment”

Disability is defined broadly in the ADA to mean “a physical or mental impairment that substantially<sup>95</sup> limits one or more of the major life activities,<sup>96</sup> a record of such impairment, or being regarded as having such an impairment.”<sup>97</sup> “Physical or mental im-

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89. Dept. of Justice Nondiscrimination on the Basis of Disability in State and Local Government Services Final Rule, 56 Fed. Reg. 35,694 (1991) (codified at 28 C.F.R. pt. 35).

90. 28 C.F.R. pt. 35, subpt. G (1993).

91. *Id.*

92. *Id.* at subpt. A.

93. *Id.*

94. As above.

95. The physical or mental impairment must substantially limit a major life activity. Persons with minor or trivial impairments’ such as a simple infected finger are not disabled within the meaning of the Act. See, SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES, S. DOC. NO. 116, 101st Cong., 2d Sess. 22 (1989).

96. *Id.* (The term “physical or mental impairment” does not include simple physical characteristics, such as blue eyes or black hair. Nor does it include environmental, cultural, and economic disadvantages in and of themselves. Thus age and homosexuality are not characterized as disabilities under the Act.)

97. See 42 U.S.C. § 12111 (1992). The definition of disability in the ADA is comparable to the term “handicap” in section 7(8)(B) of the Rehabilitation Act of 1973 and § 802(h) of

pairment" includes: (1) any physiological disorder or condition, disfigurement or anatomical loss affecting any of the major bodily systems; or (2) any mental or physiological disorder such as mental retardation or mental illness. The legislative history<sup>98</sup> as well as the prior case law,<sup>99</sup> make clear that "disability" includes diseases and infections which are communicable (e.g., tuberculosis,<sup>100</sup> hepatitis,<sup>101</sup> and HIV<sup>102</sup>) as well as those which are not (e.g., cancer,<sup>103</sup> heart disease,<sup>104</sup> arthritis,<sup>105</sup> diabetes, and epilepsy<sup>106</sup>).

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the Fair Housing Act. The Congress intended that regulations implementing the Rehabilitation Act and the Fair Housing Amendments apply to the term disability in the ADA. The use of the term "disability" instead of "handicap" represents currently acceptable terminology. *See also*, THE AMERICANS WITH DISABILITIES ACT OF 1989: REPORT OF THE COMMITTEE ON LABOR AND HUMAN SERVICES, S. Rep. No. 116, 101st Cong., 2d Sess. 21 (1992).

98. *Id.* at 22. Indeed, the House Energy and Commerce Committee rejected an amendment offered by Congressman Dannemeyer that would have expressly excluded currently contagious and sexually transmitted diseases or infections from the definitions of "disability." *See* HOUSE COMMITTEE ON ENERGY AND COMMERCE, H.R. REP. NO. 485, 101st Cong., Sess. 4 (1990) (to accompany H.R. 2273).

99. *See, e.g.*, *Strathie v. Dep't of Transp.*, 716 F.2d 227, 232-34 (3d Cir. 1983) (holding that hearing impairment problems are to be treated as disabilities); *Doe v. N.Y. Univ.*, 666 F.2d 761, 775 (2d Cir. 1981) (arguing that psychiatric problems are majority life activities which are properly classified as handicaps).

100. *See* *School Bd. v. Arline*, 480 U.S. 273 (1987) (school teacher with tuberculosis was handicapped within the meaning of § 504 of the Rehabilitation Act of 1973).

101. *New York State Ass'n for Retarded Children v. Carey*, 612 F.2d 644 (2d Cir. 1979) (mentally retarded children who are carriers of serum hepatitis B could not be excluded from public school because they were handicapped and did not pose a health hazard); *Jeffrey S., a minor by Ernest S., his father v. State Bd. of Educ. of Georgia*, 896 F.2d 507 (11th Cir. 1990) (ordering trial on the merits in case involving alleged exclusion from school because, *inter alia*, child was a carrier of hepatitis B); *Lussier v. Dugger*, 904 F.2d 661 (11th Cir. 1990) (Civil Rights Restoration Act of 1987 applied respectively to corrections officer who alleged discrimination because he had infectious hepatitis disease); *Kohl v. Woodhaven Learning Center*, 865 F.2d 930 (8th Cir. 1989), *reversing in part*, 672 F. Supp. 1221 (W.D. Mo. 1987) (inoculation of school staff for hepatitis not a "reasonable accommodation.")

102. *See, e.g.*, *Doe v. Centinela Hosp.*, 57 U.S.L.W. 2034 (C.D. Cal. 1988); *Chalk v. U.S. Dist. Ct.*, 840 F.2d 701 (9th Cir. 1988).

103. *EEOC v. AIC Security Investigations, Ltd.*, 823 F. Supp. 571 (N.D. Ill. 1993) (awarding a security company executive \$272,000 in damages, reflecting judicial reduction to statutory cap, when employer terminated him following diagnosis of brain cancer that did not affect his job performance).

104. *See* *Bey v. Bolger*, 540 F. Supp. 910 (E.D. Pa. 1982) (post office employee sought reinstatement but was denied because of his hypertension).

105. *School Bd. of Nassau County, Fla. v. Arline*, 480 U.S. 273, 283 (1987) *citing* 118 Cong. Rec. 36761 (1972) (statement of Sen. Mondale) ("a woman 'crippled by arthritis' was denied a job not because she could not do the work but because college trustees [thought] normal students shouldn't see her").

106. The Senate Labor and Human Resources Committee Report on the ADA cited examples of individuals with controlled diabetes or epilepsy who were "often denied jobs for which they are qualified." Such denials are the result of negative attitudes and misinformation. *See* S. REP. NO. 116, 101st Cong., 2d Sess. 24 (1990). In addition, in an appendix to the regulations on the Rehabilitation Act, the Department of Health and Human Services speci-

The legislative history of the Rehabilitation Act barely mentions infectious disease.<sup>107</sup> In *Arline*, the question arose for the first time in the Supreme Court whether discrimination on the basis of contagiousness constitutes discrimination "by reason of . . . handicap."<sup>108</sup> The Court held that a teacher who had been hospitalized with tuberculosis that affected her respiratory system had a "record" of substantial physical impairment. The fact that a person with a record of impairment is also contagious does not remove her from protection as a handicapped person.

The *Arline* Court observed that, in defining a handicapped person, the contagious effects of a disease cannot be meaningfully distinguished from the disease's physical effects. "It would be unfair to allow an employer to seize upon the distinction between the effects of a disease on others and the effects of a disease on a patient and use that distinction to justify discriminatory treatment."<sup>109</sup> Citing the example of cosmetic disfigurement, the Court argued that Congress was as concerned about the effects of impairment on others as it was about its effects on the individual.<sup>110</sup>

The inclusion of contagious conditions in the definition of handicap was, according to *Arline*, consistent with the basic purpose of disability law to protect people against the prejudiced attitudes and ignorance of others. "Society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from . . . impairment. Few aspects of . . . a handicap give rise to the same level of public fear and misapprehension as contagiousness."<sup>111</sup>

## 2. "Record" of or "regarded" as being impaired

A person is disabled if he or she has a "record" of or is "regarded" as being disabled or is perceived to be disabled, even if there is no actual incapacity.<sup>112</sup> A "record" indicates that the per-

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cally listed a number of diseases to which the Act applied, including epilepsy, cerebral palsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, and diabetes. 45 C.F.R. 84, App. A at 377 (1985).

107. *School Board of Nassau County, Fla. v. Arline*, 480 U.S. 273, 297 (1987) (Rehnquist, J., dissenting).

108. *See, e.g.*, Lower Courts had already found that contagious diseases were handicaps. *See e.g.*, *New York State Ass'n of Retarded Children v. Carey*, 612 F.2d 644 (2d Cir. 1979).

109. *School Bd. v. Arline*, 480 U.S. at 282 (1987).

110. *Id.* at 283.

111. *Id.* at 284.

112. This concept derives from *Southeastern Community College v. Davis*, 442 U.S. 397 (1979).

son has had a history of impairment, or has been misclassified as having had an impairment. This provision is designed to protect persons who have recovered from a disability or disease which previously impaired their life activities.<sup>113</sup> By including those who have a record of impairment, Congress acknowledged that people who have recovered from diseases such as epilepsy or cancer face discrimination based upon prejudice and irrational fear.<sup>114</sup>

The term "regarded" as being impaired includes individuals who do not have limitations in their major life functions, but are treated as if they did. This concept protects people who are discriminated against in the false belief that they are disabled. It would be inequitable for a defendant who intended to discriminate on the basis of disability to successfully raise the defense that the person was not, in fact, disabled. This provision is particularly important for individuals who are perceived to have stigmatic conditions that are viewed negatively by society. It is the reaction of society, rather than the disability itself, which deprives the person of equal enjoyment of rights and services. Persons with infectious diseases are particularly prone to irrational fears by those who are misinformed about the modes and relative risks of transmission. Persons with disfiguring conditions such as leprosy or severe burns may also suffer from negative attitudes and misinformation because they are perceived to be disabled.<sup>115</sup>

### 3. Asymptomatic infection as a disability

The fact that a record or perception of disability is included within the ADA is vitally important in determining whether pure asymptomatic infection can be regarded as a disability. The abiding interest at the time of *Arline* was whether an asymptomatic carrier of a contagious infection such as HIV could be regarded as handicapped. A Justice Department memorandum in June 1986 concluded that while the disabling effects of AIDS may constitute a handicap, contagiousness—the ability to transmit infection to others—is not a potential characteristic.<sup>116</sup> The *Arline* court in its widely studied footnote 7 claimed that the facts of the case "do not

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113. Senate Report (Labor and Human Resources Committee) No. 101-116, Aug. 30, 1989 (to accompany S. 933), p. 23.

114. *School Bd. v. Arline*, 480 U.S. at 284 (1987).

115. Senate Report (Labor and Human services Committee) No. 101-116, Aug. 30, 1989 (to accompany S. 933, p.24).

116. Opinion of Charles J. Cooper, Assistant Attorney General, Office of Legal Counsel, for Ronald E. Robertson, General Counsel, Department of Health and Human Services, June 23, 1986.

present, and we therefore do not reach, the question whether a carrier of a contagious disease such as AIDS could be considered to have a physical impairment.”<sup>117</sup>

On July 29, 1988, C. Everett Koop, the Surgeon General, wrote to the Justice Department seeking a fresh opinion in light of *Arline* and the growing scientific understanding that HIV infection is the starting point of a single disease process.<sup>118</sup> In response, the Justice Department withdrew its previous opinion, concluding that “section 504 protects symptomatic as well as asymptomatic HIV-infected individuals against discrimination.” The person is protected only if he or she “is able to perform the duties of the job and does not constitute a direct threat to the health or safety of others.”<sup>119</sup>

The applicability of asymptomatic infection to handicapped status had already been clarified in amendments to the Rehabilitation Act. The Civil Rights Restoration Act of 1987,<sup>120</sup> intended as a codification of *Arline*, states that a person with a contagious disease or infection is handicapped if he or she does not “constitute a direct threat to health or safety” and is able to “perform the duties of the job.”<sup>121</sup> Since *Arline*, the courts have consistently held that HIV-related diseases, including asymptomatic HIV infection, are covered handicaps.<sup>122</sup>

### B. Direct Threat: An Evolving Qualification Standard

#### 1. Applicability of the “direct threat” standard to all parts of the ADA.

The anti-discrimination principle in the ADA applies only to “qualified individuals.”<sup>123</sup> A “qualified” person must be capable of meeting all of the performance or eligibility criteria for the particular position, service or benefit.<sup>124</sup> There is, moreover, an affirmative

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117. *Id.* at 282, n. 7.

118. Letter from C. Everett Koop to Douglas Kamiec, Acting Assistant Attorney General, July 29, 1988.

119. Memorandum for Arthur B. Culvahouse, Jr., Counsel to the President, from Douglas W. Kamiec, Acting Assistant Attorney General, Office of the Legal Counsel, re Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals, Sept. 27, 1988. The concept of “direct threat” as a qualification standard is discussed below.

120. Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, 102 Stat. 28 (codified as amended in scattered sections of the U.S.C.).

121. *Id.* at § 9(c).

122. See e.g., *Centinela Hosp.*, 57 U.S.L.W. 2034 (D.C. Cal. 1988). See also, Lawrence Gostin, *The AIDS Litigation Project: A National Review of Court and Human Rights Commission Decisions, Part II: Discrimination*, 263 JAMA 2086-93 (1990).

123. 42 U.S.C. §§ 12112, 12133 (1992).

124. *Id.* § 12112 (requiring qualification standards, employment tests, or other selection



obligation to provide "reasonable accommodations"<sup>125</sup> or "reasonable modifications"<sup>126</sup> if they would enable the person to meet the performance or eligibility criteria. Employers are not required to provide reasonable accommodations if it would impose an undue hardship on the operation of the business.<sup>127</sup>

The key concepts of "qualification" and "reasonable accommodations" or "modifications", on their face, apply only to a person's ability to do a job or participate in public programs, with or without adaptations or modifications by the employer or public entity. A specific ban against discrimination of disabled people who are "qualified," without better established limits, might require covered entities to integrate persons in jobs, accommodations, and services, even if they posed a risk of transmission of disease. This prospect led some Congressmen to ask whether employers could be required to employ persons with AIDS if they risked "exposing others to tuberculosis, cytomegalovirus, and other AIDS-associated illness?"<sup>128</sup>

AIDS-related conditions provide poor examples because of the low risk of transmission. It does, however, defy established public health practice to suggest that persons with readily transmissible air-borne conditions could not be excluded from a particular job or enclosed public spaces such as movie theaters; that persons with food-borne diseases could not be prevented from working as a waiter in restaurants or kitchens; or that public health departments could not set reasonable rules for the control of sexually transmitted disease in bathhouses. In short, the essence of public health regulation is that persons may be treated differently based upon a rigorous scientific assessment of the risk of transmission.

Congress anticipated this problem in relation to employment and public accommodations. Titles I and IV of the ADA state expressly that qualification standards can include a requirement that a person with a disability "not pose a direct threat to the health or

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criteria to be "job-related" and "consistent with business necessity"). *See also, Id.* at § 12133 (requiring the disabled person to meet the "essential eligibility requirements" for the receipt of services or the participation in programs or activities).

125. *Id.* § 12111(b)(5).

126. *Id.* § 12111(2).

127. *Id.* at § 102(b)(5)(A). *See also, Southeastern Community College v. Davis*, 442 U.S. 397, 410-12 (1979) (holding that "unique financial and administrative burdens" or requirements which call for "fundamental alteration in the nature of the program" impose undue hardships on businesses).

128. William Dannemeyer, Joseph Barton, & Donald Ritter, House Report (Energy and Commerce Committee) No. 101-485 (IV), May 15, 1990 (to accompany H.R. 2273), p. 126.

safety of others”<sup>129</sup> if reasonable accommodations or modifications will not eliminate that direct threat. The ADA clearly provides a right to take action to protect the health and safety of all persons in employment and public accommodations.<sup>130</sup>

The question arises as to whether the same standard is similarly applicable to Title II, since the concept of “direct threat” is not expressly extended to public services. Title II is of seminal importance in the regulation of public health since it is concerned with activities of state and local government. If taken at face value, Title II could appear to undermine rules, regulations and practices of public health departments which exclude persons from services, programs, or activities because of a communicable disease. A defense of direct threat is not expressly available under Title II. As Congress likely did not intend such a result, future regulations should specifically apply the “direct threat” standard to Title II.

Title II applies only to “qualified” individuals. Although that term is not defined in Title II, it can reasonably be taken to have the same meaning as in Title I. Indeed, in discussing the qualification standards for public services, the House Committee on Energy and Commerce referred to the long-standing section 504 principle that a person must meet the basic eligibility requirements of the program, and could not pose “a significant risk . . . [to the health or safety of others] that . . . [cannot] be eliminated by reasonable accommodation.”<sup>131</sup>

## 2. Defining “direct threat”: How significant must health risks be?

By utilizing the Supreme Court’s term “direct threat,” Congress intended to codify *Arline*.<sup>132</sup> Although the “direct threat” criterion was limited to persons with contagious disease in the Senate bill, it was extended in Conference to all individuals with disabilities.<sup>133</sup> The ADA defines “direct threat” consistently with the *Arline* decision: “a significant risk to the health or safety of others” that can-

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129. 42 U.S.C. §§ 12113(b), 12182(b)(3).

130. See H.R. REP. NO. 596, 101st Cong., 2d Sess. 11 (1990) (allowing drug testing of employees in safety-sensitive positions in order to protect lawful exercises of businesses).

131. H.R. REP. NO. 485, 101st Cong., 2d Sess. 37 (1990).

132. See *Id.* at 26,51-52 (1990), *Id.* at pt. 2, 121. (The term “direct threat” is also found in the Civil Rights Restoration Act of 1988 and the Fair Housing Amendments of 1988).

133. H.R. CONF. REP. NO. 596, 101st Cong., 2d Sess. 11 (1990); H.R. REP. NO. 485, 101st Cong., 2d Sess., pt. 3, 51 (indicating that in the House, the standard of “direct threat” was extended by the Judiciary Committee to all individuals with disabilities, and not simply to those with contagious diseases or infection).

not be eliminated by reasonable accommodation in employment,<sup>134</sup> or reasonable modification of policies, practices, or procedures, or by the provision of auxiliary aids or devices in public accommodations.<sup>135</sup>

"Significant risk" therefore, becomes the standard against which public health regulation must now be measured. The question now becomes which risks are significant? It is possible to arrive at a rather sophisticated jurisprudential and public health understanding of the concept of significant risk by piecing together the language in *Arline* and the ADA's rich legislative history.

First, determination of significant risk becomes a public health inquiry.<sup>136</sup> Relevant evidence must be provided by the multiple disciplines of public health, including medicine, virology, bacteriology, and epidemiology. The science of public health provides the sole grounding for determinations of modes of transmission, probability levels for transmission, efficacy of policies and practices for interrupting transmission, and the likelihood and severity of risk. Disability law has been thoughtfully crafted to replace reflexive actions based upon irrational fears, speculation, stereotypes, or pernicious mythologies,<sup>137</sup> with carefully reasoned judgements based upon well established scientific information.<sup>138</sup>

Second, significant risk must be determined on a case-by-case basis, and not under any type of blanket rule, generalization about a class of disabled persons, or assumptions about the nature of disease. This requires a fact-specific individualized inquiry resulting in a "well-informed judgement grounded in a careful and open-minded

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134. 42 U.S.C. § 12111(3). See also, H.R. REP. NO. 116, 101st Cong., 2d Sess. 27 (1989) (suggesting that direct threat to property may also be sufficient).

135. 42 U.S.C. § 12182(b)(3) (1992).

136. See e.g., H.R. Rep. No. 485, 101st Cong., 2d Sess. 51 (1990) (to accompany H.R. 2273) (House Judiciary Committee indicating that direct threat must be based on objective and accepted public health guidelines).

137. The legislative history is replete with statements that rejecting decision making based upon ignorance, misperceptions, and patronizing attitudes. See, LABOR AND HUMAN RESOURCES COMMITTEE REPORT, S. REP. NO. 116, 101st Cong., 2d Sess. 27 (1989) (accompanying S. 933); H.R. Rep. No. 485, 101st Cong., 2d Sess. 52, 153 (1990) (accompanying H.R. 2273); pp. 52, 153; HOUSE COMMITTEE ON ENERGY AND COMMERCE, H.R. REP. NO. 485, at 38; House Committee on Education and Labor, H.R. REP. NO. 485 (II) at 77, 121. For historical works of excellence which chronicle the invidious discrimination and prejudiced attitudes toward illness and disease see, e.g., SUSAN SONTAG, *ILLNESS AS A METAPHOR* (1986); ALLAN BRANDT, *NO MAGIC BULLET: A SOCIAL HISTORY OF VENEREAL DISEASE IN THE UNITED STATES SINCE 1880* (1985); Dell, *Social Dimensions of Epilepsy: Stigma and Response*, in *PSYCHOPATHOLOGY IN EPILEPSY* 185-10 (S. Whitman & B. Hermann, eds., 1986).

138. *School Bd. v. Arline*, 480 U.S. 273, 285 (1987).

weighing of risks and alternatives.”<sup>139</sup> A specific determination must be made that the person is in fact a carrier of a communicable disease and that the disease is readily transmissible in the environment in which he or she will be situated. In the context of behavioral risks, the specific conduct must be identified and credible evidence must be provided to the effect that the person is likely to engage in the dangerous behavior. For example, if a mentally ill or mentally retarded person were to be excluded from school or a job because he or she posed a “direct threat,” objective evidence must be presented from the commission of recent dangerous acts.<sup>140</sup> If a person with a needle-borne or sexually transmitted infection were to be denied equal employment or housing opportunities, evidence of a likelihood that the person would share needles or engage in sexual activity in that setting must be offered.

Third, the risk must be “significant,” not speculative, theoretical, or remote. The ADA sets a “clear, defined standard which requires actual proof of significant risk to others.”<sup>141</sup> This is derived from the highly regarded footnote 16 in *Arline*:<sup>142</sup> “A person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk.” The Court illustrated its point by observing that a school board would not be required to place a teacher with active, contagious tuberculosis with elementary school children.

Several distinct issues emerge from the concept of significant risk: what is the standard of proof, who bears the burden of proof, and what level of risk is required? Court cases and legislative history do not provide definitive answers, but some guidance can be offered. The *standard of proof* goes to the issue of the probative value of evidence required. The standard of proof ought to be based upon clear and convincing evidence. The public health position taken should be consistent with the clear weight of scientific evidence. Restrictions on liberty ought not be based upon a minority medical opinion. A single physician’s view, for example, that HIV might be transmitted casually or from a bite is not sufficiently persuasive when compared with all the accumulated scientific evidence

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139. Hall v. U.S. Postal Service, 857 F.2d 1073, 1079 (6th Cir. 1988) quoting *Arline*, 480 U.S. 273 (1977). See also, *Mantoliete v. Bolger*, 757 F.2d 1416 (9th Cir. 1985); *Strathe v. Dept. of Transp.*, 716 F.2d 227 (3d Cir. 1983).

140. H.R. REP. NO. 485 AT 52; S. REP. NO. 116 at 27,77.

141. H.R. REP. NO. 485 at 53.

142. *School Bd. v. Arline*, 480 U.S. at 287.

data.<sup>143</sup> The proof of risk, on the other hand, need not be conclusive or decisive. "Little in science can be proved with complete certainty, and section 504 does not require such a test."<sup>144</sup>

The *burden of proof* should fall on the entity seeking to demonstrate significant risk. This is consistent with the fact that "direct threat" is a defense in Title I.<sup>145</sup> Thus, an employer, public health department, or public accommodation must be able to offer evidence substantiating its decision to treat disabled people inequitably because they pose a threat to others. It would be difficult, if not impossible, for a person with a communicable disease to prove that transmission cannot occur or is unlikely to occur.

The *level of risk* required is an imponderable because the concept of "significant" is elastic and may vary depending upon the circumstances and severity of the outcome. For example, minor or inconsequential infections might require a higher risk of transmission than lethal or fatal infections. Significant risk is not a remote risk, possibly not even an "elevated risk."<sup>146</sup> There must be a material, real, or substantial possibility that the disease can be transmitted.

The factors to be used in determining significant risk are increasingly well understood.<sup>147</sup> The decision maker must determine significant risk based upon reasonable medical judgements and the current state of scientific understanding concerning:

(a) *Mode of transmission*. The mechanism of transmission of most diseases is well established by epidemiologic research. A significant risk should be based upon a primary mode of transmission, not a mode which is unestablished or highly inefficient. A blood-borne disease, for example, could conceivably be transmitted

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143. A Maryland court has demonstrated increasing reliance on scientific data, holding that information on AIDS transmission from reputable scientific journals and institutions constituted a proper object for judicial notice. *Faya v. Almaraz*, 629 A.2d 327 (Md. 1993).

144. *Chalk v. US District Court*, 840 F.2d 701 (9th Cir. 1988).

145. While the "direct threat" standard is not framed as a defense in Title III, it is reasonable to conclude that Congress intended that the public accommodation should bear the burden of substantiating a direct threat.

146. H.R. Rep. No. 485 at 53 (stating that the decision to exclude cannot be based on merely "an elevated risk of injury").

147. The following discussion is based upon the amicus curiae brief of the American Medical Association in *Arline*, and the discussions in several of my previous works. See Larry Gostin, *The Politics of AIDS: Compulsory State Powers, Public Health and Civil Liberties*, 49 OHIO ST. L.J. 1017, 1020-26 (1989); Larry Gostin, *Hospitals, Health Care Professionals and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 MD. L. REV. 12, 15-24 (1989); Larry Gostin, *The Case Against Compulsory Casefinding in Controlling AIDS Testing, Screening and Reporting*, 12 AM. J.L. & MED. 7, 21-24 (1986).

through a bite,<sup>148</sup> through rough play among children,<sup>149</sup> or by bleeding into food.<sup>150</sup> Yet, the "significant risk" test would not be met if personal restrictions were based upon such speculative mechanisms of transmission.

(b) *Duration of risk.* A person can be subject to compulsory public health powers only if he or she is actually contagious, and only for the period of time of contagiousness. A fundamental principle of public health law,<sup>151</sup> often breached in early cases,<sup>152</sup> is the requirement that the subject must be proven by medical examination or testing to be carrying an infectious agent. "The mere possibility that persons may have been exposed [to a disease] is not sufficient . . . They must have been exposed to it, and the conditions actually exist for a communication of contagion."<sup>153</sup> The person must also be actively infectious. The key factual determination in *Arline* was whether a teacher was actively contagious and currently capable of transmitting tuberculosis through casual contact.<sup>154</sup>

(c) *Probability of risk.* The authority of the public health department to impose restrictions grows as the probability of the risk of transmission increases. The probability that a person will transmit disease is a scientific calculation that can be made with relative degrees of confidence. The range of probability that a person will contract HBV or HIV from a percutaneous exposure (e.g., a needle-stick or cut), for example, is well established by prospective studies.<sup>155</sup> The level of risk from a single sexual relationship is much

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148. See, e.g., *United States v. Moore*, 846 F.2d 1163 (8th Cir. 1988), *affirming*, 669 F. Supp. 289 (D. Minn. 1987) (holding that the mouth and teeth of an HIV infected person could be regarded as a "dangerous" or "deadly weapon."); *Indiana v. Haines*, 545 N.E. 2d 834 (Ind. App. 2d Dist. 1989) (reinstating a conviction for "attempted murder" for splattering emergency workers with HIV-contaminated blood).

149. See, e.g., *Thomas v. Atascadero Unif. School Dist.*, 662 F. Supp. 376 (C.D. Cal. 1986) (holding it unlawful to exclude an HIV-infected kindergartner who bit another child and was labelled "aggressive").

150. See, e.g., *People v. Dunn*, Florida Crim. Case, Assoc. Press release, Sept. 28, 1987 reported in Larry Gostin et al., *THE AIDS LITIGATION PROJECT*, U.S. Govt. Printing Office: Washington D.C. (1990) (convicting prisoner of introducing "contraband" into a state facility by lacing guards' coffee with HIV-contaminated blood). See further discussion of food workers *infra* § 4.

151. See Lawrence Gostin, *The Future of Public Health Law*, 12 AM. J.L. & MED. 461, 467 (1986) (discussing a series of cases with regard to this principle).

152. *Id.* at 480-83; *ex parte Company*, 139 N.E. 204 (1922).

153. *Smith v. Emery*, 11 A.D. 10, 42 N.Y.S. 258 (1896).

154. *Arline*, 480 U.S. at 287, n.16.

155. The range of risk for HIV transmission following a needle stick is between 0.03 to 0.9%, compared with 12-17% for HBV transmission. See Lawrence Gostin, *Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 12 MD. L. REV. at 17.

more difficult to calculate. Substantial probabilities of transmission based upon firm scientific calculations provide the best justification for public health powers.

(d) *Severity of Harm*. The seriousness of harm to third parties represents an important calculation in public health regulations. In assessing the validity of public health powers, a rough inverse correlation exists between the seriousness of harm and the probability of it occurring. As the seriousness of potential harm to the community rises, the level of risk needed to justify the public health power decreases.

Central to the understanding of the "significant risk" criterion is the fact that even the most serious potential for harm does not justify public health regulation in the absence of a reasonable probability that it will occur. Parents of school children, for example, have difficulty comprehending why courts would uphold the exclusion of children from school who are infested with lice, but not those infected with HIV. The reason is that a very high probability exists that other children will become infested with lice, but that the risk of contracting HIV in that setting is highly remote.

The interaction between probability and severity of risk emerges as a pointedly unresolved issue at the interface of disability law and public health regulation. Consider the application of the "direct threat" standard to an HIV infected health care professional.<sup>156</sup> While the risk of transmitting infection to the professional's patients is highly remote, the consequence to any patient infected is grave. Courts are simply unprepared to respond to this dilemma by the application of a rational set of standards.

The *Leckelt* case showed a fundamental misunderstanding of the relationship between probability and severity of risk by concluding that even though the probability of HIV transmission "may be extremely low . . . there is no cure for HIV or AIDS at this time, and the potential harm of HIV infection is extremely high."<sup>157</sup> If the seriousness of harm were dispositive it would require courts to uphold almost any restriction on a person with AIDS even if the

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156. See generally, Larry Gostin, *HIV-infected Physicians and the Practice of Secondary Invasive Procedures*, 19 HASTINGS CTR. REP. 32, 32-39 (1989).

157. *Leckelt v. Board of Comm'ns of Hosp. Dist. No. 1*, 909 F2d 820, 1990 U.S. App. LEXIS 14852, at 28-29 (5th Cir. 1990). The Court relied more on the fact that Kevin Leckelt refused to follow infection control policy by reporting his contagious conditions and submitting to HIV testing. This led the Court to conclude that the reason for his dismissal was not solely his handicap. Query, would the Court's decision be affected by the ADA language which does not use the word "solely" by reason of his or her disability?

risk were "low, approaching zero."<sup>158</sup>

Again in *Behringer* the court concluded that "(w)here the ultimate harm is death, even the presence of a low risk of transmission justifies the adoption of a policy which precludes invasive procedures when there is 'any' risk of transmission."<sup>159</sup> There, an otolaryngologist was diagnosed with AIDS at the hospital where he enjoyed surgical privileges. The hospital failed to maintain confidentiality of the diagnosis and employees and other members of the community learned of the surgeon's condition. The hospital, recognizing the risk, imposed informed consent requirements on the surgeon, and suspended then barred surgical privileges for the surgeon.<sup>160</sup>

The court held that, under the informed consent doctrine, disclosure of the risk from procedures performed by a surgeon with AIDS was required, as "the ultimate arbiter of whether the patient is to be treated invasively by an AIDS-positive surgeon . . . will be the fully-informed patient."<sup>161</sup> The court found that the hospital, while breaching its duty of confidentiality to the surgeon, acted properly in imposing conditions on the surgeons practice of medicine at the institution given the "materially enhanced risk" posed by the surgeon and the hospital's legitimate public health purpose of preventing the spread of infection.<sup>162</sup>

Likewise, in the more recent *Alvarez* case, the court went a step further, permitting recovery for two patients' fear of acquiring AIDS from an HIV-positive surgeon for the period between when the two patients learned of the surgeon's illness and received their own HIV-negative test results. There, the two patient's were operated on by a prominent breast cancer surgeon, and later learned through news accounts that the surgeon was HIV-positive.<sup>163</sup>

The court acknowledged that the patients' complaints failed to identify any actual channel of transmission for the AIDS virus, but permitted recovery for fear (and its manifestations in headaches and sleeplessness) nonetheless. The court, however, cut-off recovery for the patients' *continued* fear, reasoning that current, credible scientific evidence indicates that 95% of individuals exposed to HIV will

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158. *Glover v. Eastern Neb. Office of Retardation*, 867 F.2d 461 (8th Cir. 1989) *cert. denied*, 110 S.Ct. 321 (1989) (finding HIV screening of staff in mental retardation facility was unconstitutional because of the exceedingly low risk).

159. *Behringer Est. v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1283 (1991).

160. *Id.* at 1254.

161. *Id.*

162. *Id.* at 1276.

163. *Id.* at 329.



test positive for the antibodies to the virus within six months. The court also found that the HIV-infected surgeon had a duty to warn patients of the risk, and that the hospital might also be liable, under the doctrine of agency, for its failure to control risk.<sup>164</sup>

(e) *Human rights burdens.* While human rights burdens are often missing from public health calculations,<sup>165</sup> they are of central importance. The nature, severity, and duration of the personal restrictions must be weighed against the efficacy of the public health power. Substantial public benefit would be required to justify restrictions of great severity and/or duration. A requirement to report an infectious condition to a public health department which maintained strict confidentiality would not impose significant human burdens. A short period of exclusion from school due to infectious measles might similarly be reasonable. On the other hand, isolation for a disease without a finite period of infectiousness would be burdensome both in the degree and the duration of human deprivation. Courts must first determine if the health risk is significant. This ought to be followed by a weighing of efficacy (will the public health power reduce a serious health threat?) and burdens (at what human, social, and economic cost will the public health benefit be achieved?).<sup>166</sup>

### 3. Medical examination and testing: pre and post-test medical inquiries

The ADA specifies that the prohibition of discrimination against persons with disabilities applies to medical examinations and inquiries.<sup>167</sup> Historically, employers gathered information concerning the applicant's physical and mental condition through application forms, interviews, and medical examinations. This information was often used to exclude persons with disabilities from employment—particularly applicants with hidden disabilities such as epilepsy, emotional illness, cancer, or HIV infection.<sup>168</sup>

Employers used pre-employment medical information to avoid hiring persons with disabilities because of bias or misconceptions about their ability to do the job. As employee health insurance and

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164. *Faya v. Almarez*, 620 A.2d 327 (Md. 1993).

165. The American Medical Association amicus curiae brief in *Arline* is silent as to the impact of public health regulation on individual rights.

166. This balancing of benefits and burdens is further explained in Allan Brandt et al., *Routine Hospital Testing for HIV: Health Policy Considerations*, in LAWRENCE GOSTIN, *AIDS AND THE HEALTH CARE SYSTEM*, 125-42 (1990).

167. 42 U.S.C. § 12112(c)(2)(B) (1992).

168. See, S. REP. NO. 116, *supra* note 94, at 39.

benefit costs rose to substantial proportions of their annual operating costs, employers were driven to screen out persons who might generate substantial medical bills. Thus, many employers aggressively screened job applicants to avoid paying the health care costs of persons with potentially expensive medical conditions.

These forms of discrimination, although sometimes understandable, have been technically unlawful since the Rehabilitation Act of 1973. Enforcement, however, was exceedingly difficult, since an employer did not have to disclose that the person's disability was the sole reason for the failure to hire. So long as employers were able to conduct extensive medical examinations before offering a job, they could effectively hide the true reason for the employment decision.

The ADA's most radical departure from the Rehabilitation Act is its proscription against pre-offer medical inquiries.<sup>169</sup> Under 42 U.S.C. § 12112(c)(2), employers are prohibited from conducting medical examinations or inquiries into whether a job applicant is disabled. Pre-employment inquiries must be limited to assessing the applicant's ability to perform job-related functions.<sup>170</sup> Thus, employers may not require job applicants to undergo extensive medical examinations and screenings, including testing for communicable diseases such as tuberculosis, AIDS, or hepatitis. This will strictly limit the employer's ability to obtain information about a person's current and future illness, diseases, or genetic pre-conditions before a job is offered. From an employer's perspective, it will mean that he or she will be severely limited in holding down health insurance costs by seeking to foresee the future health status of applicants.

The ADA permits an employer to require an entrance examination only after an offer of employment has been made. All entering employees must be subjected to the same examination and the medical information must be kept strictly confidential.<sup>171</sup> Employers also have very limited rights to conduct medical examinations or inquiries after a person is hired. The employer cannot compel an employee to take a medical examination or inquire whether the employee is disabled unless the examination or inquiry is job related and consistent with business necessity.<sup>172</sup>

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169. For the purposes of the ADA, drug testing is not considered a medical examination, and employers are not prohibited from taking action against a person who is currently engaging in the alleged use of drugs. 42 U.S.C. §§ 12114, 12210 (1992).

170. *Id.* § 12112(c)(2)(B).

171. *Id.* § 12112(c)(3).

172. *Id.* § 12112(c)(4).

Congress, in enacting the ADA, recognized that a medical examination or inquiry that is not job related serves no legitimate employment purpose, but simply stigmatizes persons with disabilities.<sup>173</sup> The ADA will significantly impede the growing use of medical testing and information gathering used by employers across America, transforming the way the business community makes hiring decisions.

Even though the ADA does not significantly restrict the rights of insurers (including self-insurers) or companies administering benefit plans from underwriting risks, employers are not permitted to deny health insurance or other benefits coverage completely based on a person's diagnosis, prognosis, or disability. All people with disabilities must have equal access to the health insurance coverage provided to all employees. Employers, however, may circumvent testing restrictions by placing a cap or other limit on coverage for certain procedures or treatments for conditions such as AIDS. They may also exclude pre-existing conditions.<sup>174</sup>

While employers are permitted to establish or change plans based upon insurance underwriting principles, they are not allowed to use "subterfuge" to evade the purposes of the ADA (§ 501(c)).<sup>175</sup> In June of 1993, the Equal Opportunity Employment Commission (EEOC) issued interim guidance for enforcement of the ADA in cases of disability-based distinctions in the terms or provisions of employer-provided health insurance plans. The guidance identifies four requirements under the ADA in the area of health insurance:

1. disability-based insurance distinctions are permitted only if the plan is bona fide and if the distinctions are not being used as a subterfuge for purposes of evading the ADA,
2. decisions about the employment of an individual with a disability may not be motivated by concerns about the impact of the individual's disability on the employer's health plan,
3. employees with disabilities must be accorded equal access to whatever health insurance the employer provides to employees without disabilities, and
4. an employer may not make an employment decision about any person, whether or not that person has a disability, because of concerns about the impact on the health plan of the disability

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173. S. REP. NO. 116, *supra* note 142, at 39, 40.

174. *Id.* at 29.

175. For a more detailed discussion of the antidiscrimination principles that are applicable to health insurance and health benefits packages, see Lawrence Gostin & Alan Widiss, *What's Wrong with the ERISA Vacuum? The Case Against Total Freedom for Employers to Decide What Coverage Is to be Provided When Risk Retention Plans are Established for Health Care*. 19 J. AM. MED. ASS'N 269 (1993).

of someone with whom that person has a relationship.<sup>176</sup>

The Guidance instructs EEOC investigators to determine whether insurance terms or provisions single out particular disabilities, discrete groups of disabilities, disability in general, or specific procedures or treatments of particular disabilities or groups of disabilities. The burden of proof is placed on the employer to justify the disability-based distinction, as the employer has control of the data relied on to make the disability-based distinction decision. The employer must prove both that the plan is bona fide and that the disability-based distinction is not being used as a subterfuge to evade the purposes of the ADA. Such proof may include actuarial data supporting the employer's decision and rationale, or evidence demonstrating why non-disability-based options were considered and rejected.<sup>177</sup>

#### 4. The food handlers controversy and the preemption clause: a federalist approach

A dissenting view in the House Judiciary Committee expressed the concern that a person with AIDS could not be transferred out of a food handling position even if the employer continued to pay the same wages. This would be the "ultimate undue hardship." "Unfortunately, there are many Americans who panic at the mention of the AIDS and would refuse to patronize any food establishment if an employee were known to have the virus." This policy will "translate to no customers and no business at all."<sup>178</sup>

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176. EQUAL OPPORTUNITY EMPLOYMENT COMMISSION, EEOC ISSUES INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE ADA TO DISABILITY-BASED PROVISIONS OF EMPLOYER-PROVIDED HEALTH INSURANCE, (June 8, 1993).

177. *Id.* The EEOC's Guidance standards are being tested in a recent case filed by the EEOC against Mason Tenders District Council Trust Fund charging that an amendment to the Fund's health insurance plan violates the ADA by excluding coverage of AIDS-related conditions. Terence Donaghey, a plan participant of the multi-employer trust fund, was denied coverage for his AIDS-related illnesses. The Fund failed to provide any actuarial basis for the AIDS exclusion amendment. Under the EEOC's Guidance, disability-based exclusions may be found to be subterfuges used to evade the ADA when they are not justified by legitimate risk classification and underwriting procedures. The Fund has filed a motion for summary judgment claiming that ERISA exempts it from the purview of the ADA. The suit is pending in District Court in New York. Equal Opportunity Employment Commission, EEOC FILES LAWSUIT AGAINST INSURANCE PLAN THAT EXCLUDES COVERAGE FOR INDIVIDUAL WITH AIDS, (June 9, 1993). The EEOC won its first judgment under the ADA in June of 1993 (*EEOC v. AIC Security Investigations, Ltd.*, 823 F.Supp. 571 (N.D.Ill. 1993)), and filed two more cases in addition to *Mason Tenders* in Sept., 1993 (*EEOC v. H. Hirschfeld Sons Co.* and *EEOC v. Allied Services Division*). EEOC ADA Litigation List (Oct., 1993).

178. H.R. REP. NO. 485(III), 101st Cong., 2d Sess. 146-47 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445.

The House Amendment (the "Chapman Amendment"), but not the Senate bill, specified that it shall not be a violation of the ADA for an employer to refuse to assign or continue to assign any employee with an infectious or communicable disease of public health significance to a job involving food handling, provided the employer makes reasonable accommodation to offer a comparable alternative employment opportunity.<sup>179</sup> The House receded to the Senate with the following amendment: The Secretary of Health and Human Services must publish a list of infectious and communicable diseases which are transmitted through handling of the food supply, specifying the methods by which such diseases are transmitted, and widely disseminating the information about the dangers and their modes of transmission.<sup>180</sup>

The ADA authorizes employers to refuse to assign individuals to a job involving food handling if they have a presently infectious condition that is listed as transmissible through the food supply.<sup>181</sup>

The Chapman Amendment contained the fundamental misconception of disability law that it is permissible to fire an employee if the reason for the discrimination is not the employer's biases, but to protect the business from the irrational fears of patrons. The courts do not allow employers to succumb to wholly unsubstantiated fears of customers as a justification for discrimination, even if this involves picketing of the establishment.<sup>182</sup> Exclusion of HIV-infected food handlers was not condoned under the Rehabilitation Act and state handicap law because of the absence of any evidence that infection could be transmitted through food.<sup>183</sup>

The purpose of the food handlers compromise was to ensure the American public that "valid scientific and medical analysis, using accepted public health methodologies and statistical practices regarding risk of transmission" will be brought to bear in analyzing food-borne transmission of disease.<sup>184</sup> This is the same standard that ought to be applied to future public health decision making.

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179. H.R. CONF. REP. NO. 596, 101st Cong., 2d Sess. 12-13 (1990), *reprinted in* 1990 U.S.C.A.N. 565.

180. 42 U.S.C. § 12113(d)(1) (1992).

181. *Id.* § 12113(d)(2).

182. *Mosby v. Joe's Westlake Restaurant*, Cal. Super. Ct., San Francisco County, No. 865045, *reported in* Larry Gostin, *The AIDS Litigation Project: A National Review of Court and Human Rights Commission Decisions; Part II: Discrimination*, 286 JAMA 2086, 2086-93 (1990).

183. *See, e.g., Little v. Bryce & Randall's Food Market*, 733 F.2d 937 (Tex. App. Hous. 1st Dist. 1987).

184. H.R. Conf. Rep. No. 596, 101st Cong., 2d Sess. 14 (1990).

The food handlers controversy was a largely irrelevant Congressional pandering to the unsubstantiated fears of the public about AIDS. What emerged as a problem of significant import, however, was the interaction between the ADA, and state or municipal public health statutes. Federal laws, unless they specify otherwise, preempt state and local statutes with comparable coverage. The ADA specifies that state or local law which creates "*greater* protection for the rights of individuals with disabilities" is not preempted.<sup>185</sup> The question arises whether public health laws which *restrict* a disabled person's rights more than the ADA allows is preempted. The simple answer is that all state and local public health law which restricts the rights of persons with communicable diseases in ways which are inconsistent with the ADA will be invalidated by federal courts. Although the preemption provision in 42 U.S.C. § 12113(c) applies only to food handlers, it illustrates clearly the interaction of the entire ADA with public health law. That section specifies that state, county, or local law or regulation designed to protect the public health from individuals who pose a significant risk of contamination of the food supply is not overruled or modified by the ADA.

The House Conference Report emphasizes that section 103(c)(3) "clearly defines certain types of existing and prospective state and local public health laws that are not pre-empted by the ADA."<sup>186</sup> The public health law must be designed to protect the community from significant public health risks which cannot be eliminated by reasonable accommodation. This pre-emption strategy supports legitimate state and local laws and regulations designed to protect the public from communicable disease, thus carrying out "both the letter and the spirit" of the ADA.<sup>187</sup>

The ADA appears to interfere with the classic constitutional principle that the state has sole police power authority to preserve the public health. True federalism, however, provides states with ample authority to regulate public health, but only within national guidelines ensuring that decisions are based upon rigorous public health evidence, rather than on false perception, unsubstantiated fears or pure prejudice. Properly understood, the ADA strikes a constitutional balance that can only generate better and more consistent public health decision making.

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185. 42 U.S.C. § 12201(b) (1992) (emphasis added).

186. H.R. CONF. REP. NO. 596, 101st Cong., 2d Sess. 17-18 (1990).

187. *Id.*

### CONCLUSION: A STANDARD OF PUBLIC HEALTH REVIEW BASED UPON ANTI-DISCRIMINATION PRINCIPLES

The Americans with Disabilities Act emerges as far more effective in reviewing public health powers than deferential constitutional analysis. The standard of review proposed in this paper would place the burden of proof on public health authorities to demonstrate by rigorous scientific assessment: the mode of transmission is well established; the person is currently contagious and is likely to remain so for the duration of the control measure; a reasonable likelihood exists that the person will actually transmit the disease if the control measures are not applied; the transmission of disease may result in serious harm; and the costs and human rights burdens are not disproportionate to the public health benefit to be achieved.

This standard is exacting and requires the public health department to have a clear basis for the exercise of its powers. The reason for the more focused review is that the ADA re-states the fundamental question that courts must ask of public health regulators. No longer must the courts ask what risks an uninformed, perhaps prejudiced, public is prepared to tolerate. Instead, courts should inquire whether there is sufficiently convincing evidence of harm to the public to justify discrimination against a person with disabilities. Once the issue is framed as coming within the corpus of anti-discrimination law, rather than the vague and undifferentiated traditions of the police powers, a whole new way of thinking about public health law becomes possible.